Prescription Drug Fax Authorization

Fax Number 360 725-2141

April 1, 2004

- MAA Staff will give fax requests the highest priority
- Please use the fax process for all of your authorization requests, except for emergency situations

We will respond to all fax requests within 24 hours. Our hours of business are Monday through Friday, 9:00 a.m. through 4:45 p.m. (not including holidays)

- If you do not receive a response to your faxed request within 24 hours of submitting a request, including weekends and State holidays, you may dispense an emergency fill of prescription drugs covered by the Medical Assistance Drug Program that require authorization. Please contact the Medical Assistance Pharmacy Program with justification within 72 hours of the fill date.
- Older claims – those filled over three business days prior to fax request being sent - will have a maximum response time of ten business days
- Notice will be sent to the pharmacy if it is determined we need to pend for physician information
- Pended cases will have a maximum response time from the prescriber of seven business days from date request sent
- Prior Authorization request form must be sent in to MAA via fax
- **NOT ACCEPTING EMAIL REQUESTS AT THIS TIME**

Please note that you must call if requesting an authorization for a refill too soon or excessive fills unless you can use the override for monitoring. Please see Billing Instructions

We will continue to take calls for those patients that are waiting in the pharmacy.

If you have questions about a claim or need to check on a lost or stolen medication, please call 1-800-562-6188

Prescription Drug Authorization Fax Request Form

Drug Utilization Review Team

http://maa.dshs.wa.gov/pharmacy/ Fax: (360) 725-2141

Phone: 1-800-848-2842 **Monday – Friday 9:00am to 4:45pm**

Assuring the highest quality of care by guiding the appropriate use of drugs for Medicaid clients.

*******Please note: You must transmit a claim prior to faxing this form.*******

Authorization Type

- ☐ Update to existing authorization #_____
- ☐ New request

Pricing Conflicts

- ☐ DAW**If DAW, has patient tried generic?____Outcome?_____

Patient Information

Name_____

PIC

Nursing Home Patient? Y☐ N☐ Unk ☐

History of GI bleed? Y☐ N☐ Unk ☐

Diagnosis/medical justification_____

_____

What alternatives have been tried? Dates?_____

_____

Drug Information

Drug name_____

NDC_____

Date(s) of fill_____

Rx#_____

Directions for use (sig)_____

Quantity_____

Days supply_____

Pharmacy Information

Pharmacy Name_____

NABP_____

Fax: _____

Prescriber Information

Prescriber Name_____

DEA#_____

Specialty_____

Phone_____

Fax_____

FOR DSHS/MAA STAFF USE ONLY

☐ *Form not complete or illegible. Unable to process request. Please complete and refax*

☐ *Meets EPA#*_____

☐ *Authorized. Use #*_____

☐ *Request received. Pending for more information/justification from physician.*

☐ *Denied*

☐ *Other*

Name of contact person @ Rx_____

If you have not received a response within 24 business hours, please contact us.

MAS

Date

April 1, 2004